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NO. 80-1417

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

MARK MILLS, ET AL.,

PETITIONERS,

v.

RUBIE ROGERS, ET AL.,

RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR ADVOCATES FOR BASIC LEGAL EQUALITY, INC. AS AMICUS CURIAE

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INTEREST OF AMICUS CURIAE

Advocates for Basic Legal Equality, Inc. is a nonprofit corporation located in Toledo, Ohio, which provides free legal services to eligible low income people who reside in a fourteen (14) county area in northwestern Ohio. At the request of the United States District Court for the Northern District of Ohio, Western Division, attorneys on the staff of Advocates for Basic Legal Equality, Inc. (hereinafter ABLE) represent the plaintiffs and a class of all patients at Lima State Hospital, a state operated facility for the criminally insane, in Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980). Earlier opinions in this case are Davis v. Balson, 461 F. Supp. 842 (N.D. Ohio 1978) and Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974). In Davis v. Hubbard, the court held that patients at Lima State Hospital have the right to refuse psychotropic medication, except in emergency cases, until a hearing

can be held. Id, at 925-939. On May 18, 1981 the court issued an order establishing the hearing procedure for patients who refuse psychotropic medication.

In addition, ABLE's Board of Trustees has established as a priority area the continued legal representation of institutionalized people with mental disabilities including the continued advocacy of the right of such persons to refuse psychotropic drugs.

ABLE has received consent to file this brief from both petitioners and respondents. Their letters of consent are being filed with the Clerk of this Court.

INTRODUCTION AND SUMMARY OF ARGUMENT

Amicus submits this brief in support of plaintiffs below. While amicus supports plaintiffs' view of the constitutional issues, amicus does not address these issues in this brief. Instead, amicus will discuss the actual results experienced at a psychiatric institution whose patients were provided a limited right to refuse psychotropic drugs.

Attached hereto as Exhibit A is the

deposition of Dr. Lewis Lindner, Clinical Director of Lima State Hospital, which was taken on September 21, 1981. In this deposition, Dr. Lindner tells of his experience in conducting the hearings required by the court in Davis v. Hubbard, 506 F. Supp. 915, 939 (N.D. Ohio 1980). Amicus believes that the recent experience of Lima State Hospital in allowing some patients to refuse antipsychotic drugs will assist the Court in determining what the consequences are of a decision to allow the plaintiffs in the case at bar to refuse antipsychotic drugs.

In their brief, the state defendants assert the following two arguments: (1) "The commonwealth has a compelling state interest in preventing the chronicity and warehousing that would follow from allowing patients to refuse their antipsychotic medication," Brief of Petitioners at 59, and (2) "The commonwealth has a compelling state interest in maintaining acceptable medical standards." Brief of Petitioners

at 64. Under the first argument, petitioners claim that allowing patients to refuse medication will lead to increased chronicity [1] and "warehousing" of patients. In short, the state defendants argue that a decision to allow patients to refuse antipsychotic drugs will lead to a return of the conditions of bedlam which prevailed in insane asylums in the 19th and early 20th century. Amicus will demonstrate that this has not been the case at Lima State Hospital and that there is no reason to think it would become the case at Boston State Hospital.

The state defendants further argue that medical standards require that institutionalized mental health patients be given antipsychotic drugs involuntarily. They also claim, "the bottom line [is] that there is apparently no major hospital today that attempts to treat major psychiatric illness without psychotropic drugs." Id. at 66.

1/ For the purpose of this case, amicus will use the term "chronicity" to describe mental illness which is long lasting or often recurring.

Amicus will demonstrate that this is not the case. Lima State Hospital has successfully allowed its patients a limited right to refuse antipsychotic drugs, and the Clinical Director's deposition demonstrates that the hospital has experienced no significant treatment or behavior problems with patients who have refused medication.

ARGUMENT

I. "WAREHOUSING" NEED NOT BE THE RESULT OF PSYCHIATRIC PATIENTS' REFUSAL TO ACCEPT ANTIPSYCHOTIC DRUGS.

The state defendants claim that "Allowing institutionalized patients to refuse antipsychotic medication would increase the warehousing of these patients." Brief for Petitioners at 61. This sweeping assertion contains an implicit threat that if the Court allows the patients to refuse medication, the defendents will not provide any other treatment for them and will simply warehouse them. This has not been the experience of Lima State Hospital, nor need it be at Boston

State Hospital or any other hospital treating the mentally disturbed.

In Davis v. Hubbard, 506 F. Supp. 915, 939 (N.D. Ohio 1980), the court held that patients at Lima State Hospital have a limited right to refuse antipsychotic drugs until a hearing can be held. On May 18, 1981, the court ordered the establishment of a procedure for patients, who refused medication, requiring that hearings be conducted by the Clinical Director, or his designee. On June 1, 1981, the court added provisions for appeals from the Clinical Director's decision to an independent reviewing psychiatrist.

On September 21, 1981, amicus deposed Lewis A. Lindner, M.D., the Clinical Director, who supervises a staff of seven psychiatrists at the Lima State Hospital. Dr. Lindner testified that he had conducted all the hearings under this procedure from the first week in July, when it began, until September 21, 1981. Exhibit A, attached hereto at 10.

Of the approximately 62 cases he heard, he decided approximately 16 in favor of the inmate's right to refuse. Exhibit A at 12. Thus, in 25% of the cases the treating physician's prescription of an antipsychotic drug was reversed after a hearing. This Court has considered reversal rates in administrative proceedings of 19.4% to 26.1% to be significant. Fusari v. Steinberg, 419 U.S. 379, 383 (1975).

Dr. Lindner testified that the patients refusal of medication had led to no behavior problems on the part of the patients, with the exception of a "small number" of patients who persisted in advocating for their rights to refuse without a proper understanding of what rights they had, and one patient who "manipulated" other patients into exercising their rights to refuse over a one week period. Exhibit A at 16. This is hardly the "contagion of refusal" the state defendants say they experienced. Brief of Petitioners at 64.

The refusal of the Lima State patients to accept medication did not interfere with their treatment, except for some cases at the beginning of implementation of the order where patients refused medication and the staff failed to schedule hearings for several days. Exhibit A at 13. Dr. Lindner also cited one case where the hearing decision was against the patient's right to refuse, but the staff failed to impose the medication for several additional days. Id.

Actually, over the three (3) month period, Dr. Lindner had noticed a distinct improvement in treatment at the hospital. Exhibit A at 19. There was a decrease in polypharmacy, which is the mixing of two or more antipsychotic drugs, a practice of which psychiatrists disapprove, and an increase in the use of other forms of treatment, including psychotherapy. Exhibit A at 19, 20. While Dr. Lindner did not specifically claim that the improvements in treatment were causally

related to the institution of the hearing procedure, this Court cannot help but be aware of the likely influence of this procedure on hospital psychiatrists, who now know that their medication decisions are likely to be reviewed.

In addition, Dr. Lindner gave his opinion that the procedure is beneficial for patients, because it enhances their belief that they are being dealt with fairly, and tends to reduce paranoid feelings. Exhibit A at 17-18. Dr. Lindner categorically states that a policy of allowing inmates to refuse medication does not increase the warehousing of such patients. Exhibit A at 21. In his opinion, there are many other forms of treatment available, so there is no need to warehouse these patients. Exhibit A at 22. As he put it:

> If the use of informed consent for psychotropic medication has any influence on the matter at all, I would rather expect that it would decrease the warehousing inasmuch as one of the dangers of the

> effectiveness of medication is to tend towards the assumption that it is in and of itself sufficient for the treatment of psychoses, a tendency which is undoubtedly augmented by the fact that it is also the cheapest of all treatments.

Exhibit A at 22.

II. SINCE CHRONICITY IS ONE OF THE DEFINITIONAL CHARACTERISTICS OF SCHIZOPHRENIA, THE STATE DEFENDANTS CANNOT POSSIBLY DEMONSTRATE THAT A PATIENT'S REFUSAL TO ACCEPT ANTIPSYCHOTIC MEDICATION CAUSES CHRONICITY.

The state defendants assert that, "without psychotropic medication, schizophrenic patients have a high probability of chronicity developing." Brief of Petitioners at 61. Amicus does not agree. 2/ In Dr. Lindner's opinion schizophrenic patients have a high probability of developing chronicity due to the way schizophrenia is defined by the psychiatric profession. He stated that the narrow

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2/ One set of authors on which the state defendants and the American Psychiatric Association rely states, "Whether refraining from treatment militates in favor of chronicity of illness is an additional unanswered query." Applebaum and Gutheil, Drug Refusal: A Study of Psychiatric Inpatients, 137 American Journal of Psychiatry 340, 345 (1980).

definition of schizophrenia currently used by the psychiatric profession, "almost makes chronicity a prerequisite for the diagnosis." Exhibit A at 20-21. As Dr. Lindner explained, DSM III, the working manual of psychiatrists which is used by them in diagnosing schizophrenia, contains several factors such as the existence of symptoms of schizophrenia continuously over the immediately preceeding six month period; thus making chronicity part and parcel of the definition of schizophrenia. Id. In other words, schizophrenia, as defined by DSM III, is a chronic condition. Dr. Lindner also testified that antipsychotic drugs are used primarily to treat schizophrenia, and that approximately 80% of the patients at Lima State Hospital receive antipsychotic drugs. Exhibit A at 6, 25. In this context, one can clearly see that, while the psychiatric profession freely prescribes antipsychotic drugs, schizophrenia is nevertheless a chronic illness irrespective of the treatment

provided. Thus, the presence or absence of antipsychotic drugs would appear to have little impact on the reduction of schizophrenia symptoms.

Dr. Lindner's testimony demonstrates that individualized decision-making is what is clearly required in cases of refusal of antipsychotic drugs. The state defendants insist that "Medical standards mandate treating institutionalized patients with antipsychotic drugs over their objections." Brief for Petitioners at 64. Yet, as demonstrated by Dr. Lindner, no harm has come to any of the patients at Lima State Hospital who have refused medication, even though some have schizophrenia, Exhibit A at 21. Dr. Lindner expressed the view that the district court's order adequately provides that all patients who need the medication will receive it, and in fact has led to greater cooperation on the part of the inmates with their treatment programming. Exhibit A at 22, 18.

CONCLUSION

In their brief, the state defendants argue essentially that the plaintiffs and all other patients will suffer if this Court affirms their right to refuse medication. They refer to the horrible conditions which existed in mental institutions before the introduction of psychotropic drugs and imply that these conditions will return, should the Court affirm the judgment in this case. Brief for Petitioners at 62-63. Amicus has demonstrated that such an outcome is neither inevitable nor, provided the treatment personnel at defendants' institution are reasonably competent mental health professionals, even foreseeable. Amicus also submits that a decision to affirm in this case could possibly lead to better treatment for patients, less polypharmacy, and more alternative forms of therapy, including psychotherapy. Amicus has shown that a decision to allow psychiatric patients to

refuse antipsychotic medication does not lead to bedlam and that there is no basis for the fears conjured up by the defendants. It is for these reasons that amicus urges this Court to affirm the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

Advocates for Basic Legal Equality, Inc.

By:

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STATE OF OHIO)
(ss:
COUNTY OF LUCAS)

Joseph R. Tafelski being first duly sworn deposes and says: That to my knowledge three copies of the foregoing brief were sent by first class U.S. Mail, postage prepaid, to each of: Richard W. Cole, Greater Boston Legal Services, 466 Blue Hill Avenue, Roxbury, Massachusetts 02121, Counsel for Respondents; Stephen Schultz, Administrative and Legal Counsel to the Attorney General, Commonwealth of Massachusetts, Department of the Attorney General, John W. McCormack, State Office Building, 1 Ashburton Place, Boston, Massachusetts 02108, Counsel for Petitioners; and the Mental Health Project, 2021 L Street, N.W., Suite 800, Washington, D.C. 20076, Counsel for Amici Curiae, the American Psychological Association, the American Orthopsychiatric Association, the National Association of Social Workers and the

National Association for Mental Health

this 30th day of September, 1981.

Joseph R. Tafelski

SWORN to before me and subscribed in my presence this 30th day of September, 1981.

NOTARY PUBLIC

GLENN G. GALBREATH
Notary Public -- State of Ohio
My Commission has no Expiration Date
Section 147.03 O.R.C.

EXHIBIT A

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF OHIO

WESTERN DIVISION

- - -

John A. Davis, et al.,	:	
Plaintiffs,	:	
vs.	:	Case No. C 73-205
Ronald Hubbard, et al.,	:	
Defendants.	:	
United States of America,	:	
Amicus Curiae.	:	

- - -

Deposition of Lewis A. Lindner, a witness called by the Plaintiffs herein for cross examination under the statute, as taken before me, Judy E. Love, a Notary Public within and for the State of Ohio, at the offices of Murphy, Young and Smith, 250 East Broad Street, Columbus, Ohio, on Monday, September 21, 1981, commencing at approximately 9:30 a.m. and concluding on the same day, pursuant to stipulations.

APPEARANCES:

JOHN C. HOLME, JR., Advocates for Basic Legal Equality, 740 Spitzer Building, Toledo, Ohio 43604, appearing on behalf of the Plaintiffs.

PAUL M. AUCOIN, of the firm of Murphy, Young and Smith, 250 East Broad Street, Columbus, Ohio 43215, appearing on behalf of the Defendants.

- - -

MR. HOLME: This is a deposition as on cross examination pursuant to notice and subpoena in the case of Davis versus Hubbard.

It is hereby stipulated and agreed as follows: That this deposition is taken for the purpose of Advocates for Basic Legal Equality filing an Amicus Curiae brief in support of Ruby Rogers, et al, Respondents, in the case of Mills versus Rogers which is pending in the United States Supreme Court.

Abel intends to attach portions of this deposition as an exhibit to the Amicus Curiae brief.

Do you so stipulate?

MR. AUCOIN: We so stipulate.

MR. HOLME: Mr. Aucoin, do you stipulate as to the qualifications of the Notary and the adequacy of notice?

MR. AUCOIN: Yes.

MR. HOLME: Do you waive the reading and signing of the deposition by Dr. Lindner?

MR. AUCOIN: Yes.

MR. HOLME: And does Dr. Lindner also waive the reading of the deposition?

DR. LINDNER: Yes, I do.

AUCOIN: The Defendants in this case are willingly providing Dr. Lindner because it is felt that his experience during the month of July, August, and September of 1981, as well as his training in his field, may be helpful to the Supreme Court in their effort to reach a decision in the Rogers case.

It is not intended to be a legal admission of any kind, but merely a recitation of Dr. Lindner's medical opinions and his observations and impressions regarding the facts of the due process system that was implemented during 1981 at Lima State Hospital.

- - -

(Witness sworn.)

- - -

LEWIS A. LINDNER

of lawful age, being first duly sworn to tell the truth, the whole truth, and nothing but the truth, as hereinafter certified, deposed and testified as follows:

CROSS EXAMINATION

BY MR. HOLME:

Q Would you state your name, please?

A First name, Lewis, L-e-w-i-s; middle initial A., Lindner, L-i-n-d-n-e-r.

Q Where are you employed, Dr. Lindner?

A At the Lima State Hospital.

Q Where is that located?

A In Lima, Ohio.

Q What is your position there?

A I am the Clinical Director.

Q How long have you been Clinical Director at Lima State Hospital?

A Since July, 1979.

Q How long have you been employed at Lima State Hospital?

A I have been employed full-time since July, 1976. I was a part-time consultant at that

institution for -- or assigned to that institution specifically for the two preceeding years.

Q What was your position at Lima State Hospital immediately before becoming Clinical Director?

A The Director of the Receiving Unit.

Q When did you become Director of the Receiving Unit?

A In July, 1976.

Q Doctor, what medical school did you attend?

A Ohio State University.

Q When did you graduate?

A In 1960.

Q Did you become licensed as a medical doctor in 1960 also?

A Yes, sir.

Q Have you done research in the area of mental illness?

A Yes, sir.

Q Have you published any papers in that field?

A Yes, I have.

Q How many papers have you published?

A I would estimate a dozen to 15.

Q Have you taught at any medical schools?

A Yes, I have.

Q Which ones have you taught at?

A At Ohio State University.

Q What subjects have you taught there?

A Psychiatry; also, I have assisted in teaching mental disability and the law in the College of Law at Ohio State University.

Q During what period have you taught psychiatry at the Medical School?

A Since 1961.

Q What are antipsychotic drugs, Doctor?

A A group of drugs not all chemically related that are used in reducing the symptoms of the psychoses; principally, schizophrenia.

Q What are the most common antipsychotics?

A Thorazine, Mellaril, Haldol, Stelazine, Trilafon, Navane, Loxitane, Moban, Prolixin.

Q What other psychoses are the antipsychotics used to treat other than schizophrenia?

A They are used frequently in treating organic brain syndromes that result in psychoses, and also, in treating manic states.

Q Are they used to treat any other forms of mental illness other than psychosis?

A In practice, they are frequently used by -- are used in the treatment of other disorders that result in anxiety. However, this is a practice

primarily engaged in by nonpsychiatric physicians and is generally considered undesirable medical practice.

Q Is the use of the antipsychotics at Lima State Hospital limited only to people who are diagnosed as having some form of psychosis?

A To my knowledge, yes.

Q What difference, if any, is there between antipsychotic drugs and psychotropic drugs?

A The term "psychotropic drugs" is a vague term, whose definition is not clear or generally accepted, and it varies from situation to situation.

Some people will use it as narrowly as being identical with antipsychotic drugs; other people will use it as broadly as any drug that affects mood and behavior.

Q As a psychiatrist at Lima State Hospital, have you had occasion to prescribe antipsychotic drugs to inmates at Lima State Hospital?

A I would prefer to use the term "patients" for our clients.

Q I will rephrase that accordingly.

A Yes, I have.

Q I call your attention to the Court's Order of May 18, 1981, and the policy on patients' rights

to refuse medication.

Are you familiar with that Order?

A In general terms, yes.

Q Are you also familiar with the policy on patient rights to refuse medication?

A Yes, I am.

Q Would you describe briefly in your own words what the order requires?

A Inasmuch as I have not had an opportunity to review the Order specifically in the past several months, I don't believe I can separate it in my mind from the policy. I don't think I can differentiate the two.

Q What is your understanding of what the Court has ordered in this Order?

A That patients do have a limited right to refuse antipsychotic medication.

Q How is the right limited?

A In that it is subject to limitation both for emergency when there is obvious and clear threat to the physical safety of persons, and also limited in that it is subject to review first by the Clinical Director, and secondly, on appeal by an independent psychiatrist.

Q In the first limitation where there is a threat to the safety of others, what does the policy provide?

A The policy provides that a psychiatrist can find a state of emergency and impose the medication involuntarily for a period of 72 hours pending review by the Clinical Director and with a provision for renewal for another 72-hour period.

Q In the second limitation, where a patient refuses subject to the review of the Clinical Director, and the appeal to the independent psychiatrist, does the patient get the medication between the time when he refuses and the time of the hearing?

A Not unless an emergency is declared.

Q So we are talking about a two-step appeal procedure here, are we not?

A If you are including the Clinical Director's review, yes, that would be a two-step procedure.

Q Followed by an appeal to whom?

A To an independent psychiatrist.

Q Who conducts the hearings which are required by this Order?

A As Clinical Director, I conduct the hearings in the first step.

Q Have you conducted all of the hearings which have been held pursuant to this Order?

A Yes, with the exception of the appeals from my hearings.

Q Yes, and when did you begin holding these hearings?

A The first week of July, 1981.

Q What was the population at Lima State Hospital at that time?

A As nearly as I can recall, about 320 patients.

Q What was the population during August, 1981?

A There is no simple answer because the population was decreasing very rapidly.

Q Let's take August 31st.

A I would estimate 250.

Q What is the population today?

A About 240.

Q Now, with reference to the types of commitments to the hospital, what categories of patients are there at Lima?

A The patients at Lima now legally fall into only two categories: Ones that are probated pursuant to Ohio Revised Code Section 5122, and the second category who are -- and a much smaller category --

who are committed there as incompetent to stand trial pursuant to Revised Code Section 2943.38. The first category, those patients who are probated, have several subdivisions by source, the largest group being patients who have been probated from correctional institutions and a much smaller group consisting of patients who have been probated following a finding of not guilty by reason of insanity, although it was formerly the case that they were also patients probated directly from civil status or as parolees under separate statutory provision.

I believe at the present time, all of these patients have been transferred out of the hospital.

Q Were the categories of patients at the hospital any different on the first of July than they are now?

A Yes.

Q What additional categories did you have there at that time?

A There were a number of patients who had been directly probated; that is, civil commitments without criminal charges pending.

Q And in addition, you had all the categories

of patients that are there now?

A Yes.

Q How many hearings have you held since the first of July?

A Approximately 62.

Q In how many of those cases have you upheld the patient's right to refuse medication?

A Approximately 16.

Q Now, are there any cases in which an inmate's refusal of medication under this procedure has interfered with his treatment?

A The only cases I am aware of in which it has interfered with the patient's treatment were cases in which the policy was not in fact followed, and in which patients were -- patients who refused medication, that there was no follow-up on referral to my office until a later date.

Q No follow-up referral to your office? I don't quite follow you.

A The procedures provides that when a patient refuses medication, my office is to be notified so that a hearing can be had. There were several cases at the beginning of implementation when the nurses who had attempted to obtain consent did not notify my office and the patients went for

several days without medication and without review.

There is also one case I am aware of, of a patient who refused, had a hearing in which the prescription was affirmed, but continued to verbalize refusal afterwards and the staff failed to impose the medication for an additional period of several days.

Q In the cases you mentioned where there was some delay in bringing the patient's refusal to take medication to your attention so that you could hold a hearing, did those patients go without any other form of treatment during that period as well?

A No.

Q In the cases where you have allowed patients after a hearing to refuse medication so that they then continued to be without medication, has that interfered with their treatment?

A Not to my knowledge, no.

Q Would you have knowledge of such cases if that had occurred?

A I should, but realistically, I cannot say that in a hundred percent of cases, the established procedures are followed.

Q What are the established procedures with regard to this area?

A If a patient is having difficulty, it is

normal procedure for my office to be notified so that a psychiatrist can be assigned to review the situation. There are occasional instances where this does not take place.

Q Doesn't every patient at the hospital have a psychiatrist.

A Yes, he does.

Q So if this hypothetical patient were to be allowed by you to refuse medication and would have some difficulty, does the procedure require his psychiatrist to inform you that there are difficulties?

A That is not a part of this policy, but it is implicit in the -- let me alter that. Make that categorically "no."

Q Okay.

Is there a practice at the hospital that if that problem arose, that the psychiatrist for that patient would advise you?

A No, it would in fact be the normal practice that he would be expected to deal with the problem himself unless some special situation arose.

Q So why do you say that if such a problem arose, that you should be told of it?

A I am having some trouble remembering what the original question was that started this whole line

of inquiry. Can we go back and refresh my memory a bit?

MR. HOLME: Would you reread the question?

(Question read.)

BY MR. HOLME:

Q Why don't you just answer that question and give your clarification.

A My several preceeding answers were in error. If a patient does experience difficulty, his regular assigned psychiatrist is expected to take the appropriate steps to cope with the problem, and it is unnecessary then for me to be notified unless some special circumstances intervene, such as the problem continuing, despite all efforts to cope with it by the regular treatment team, or such as a dispute arising within the team as to the appropriateness of the action taken.

Q So you are implying that if there is a problem, it is not a problem that has lasted and become an on-going problem?

A Yes, it has not been sufficient to come to the attention of my office certainly.

Q How many psychiatrists are there who treat patients at Lima State Hospital?

A Seven.

Q Do you have contact with them on a weekly basis or a daily basis?

A Irregularly, depending on needs with the exception of monthly medical staff meetings.

Q Are there any cases where an inmate's refusal of medication has interfered with the treatment of another inmate or patient?

A With the single exception which occurred primarily at the very initiation of the procedure wherein some patients who refused medication encouraged and manipulated others also to refuse medication; I am not aware of any others.

Q How long did that problem continue where one patient was encouraging another to refuse?

A About a week.

Q Are there cases where a patient's refusal of medication has led to behavior problems on the part of that patient?

A Yes.

Q What kinds of problems have you encountered?

A A small number of patients have become unusually insistent on their right to refuse medication, based primarily upon an inability to understand the procedure as a result either of psychosis or mental retardation.

Q In any of these cases, have you, after a hearing, allowed these patients to continue to refuse?

A Could I have the previous question, please?

(Question read.)

THE WITNESS: As nearly as I can recall, no.

BY MR. HOLME:

Q Do you have an opinion as to whether the hearing process itself is beneficial to the patient?

A Yes.

Q What is your opinion?

A I believe that it is.

Q What is the basis for your opinion?

A I think there are several benefits that come from it. In the first place, the patient does not feel that he is a victim of the system to the same degree as formerly; he now feels that he has some control and input, that he didn't feel he had before.

As a consequence, there seems to be much less arguing and opposition to medication throughout the hospital. Most of the patients in the hospital are much more cooperative with their medication now; even those who refuse, and still, for one reason or another, believe they should not be taking it; even if that view is upheld, feel vindicated and

tend to be more cooperative with the system in other treatment, or at least, in most cases, feel that they were treated more fairly and tend to project less paranoid feelings on the staff.

Q How do you proceed if a patient refuses and there is some question whether that patient is competent to refuse, but he doesn't have a guardian and he hasn't been declared incompetent by a court?

A We take the conservative approach and act as if he were incompetent and hold the necessary hearing.

Q How do you proceed if there is some question about an inmate's competence to accept medication, but he doesn't have a guardian and has not been declared competent by a court and he does accept the medication?

A Again, if that issue were raised, we would proceed conservatively and hold a hearing.

Q Has that particular case come up so far?

A I think there were a few early cases when the policy was first instituted, first implemented where the nurses referred patients, even though they did not object, or cases in which they refused to accept a signature of consent when they felt that it was not a knowing consent.

Q Was that done because the nurses were trained to make those referrals or did they do it on their own initiative?

A That was on their own initiative.

Q How do you proceed when a patient arrives at a hearing and tells you that he has changed his mind and he now wants to accept the medication?

A I question him very closely about his change to ascertain that it is in fact knowing and voluntary. If I can satisfy myself that that is the case, then I permit him to go ahead and sign a consent and do not hold the hearing. If there is any question about the validity of his consent, I go ahead with the hearing.

Q How long does the normal hearing take?

A Twenty minutes to a half an hour.

Q Have you noticed any improvement in treatment at Lima State Hospital since you began holding these hearings?

A You asked the question previous -- well, I am not sure you have. Yes, I have.

Q What have you noticed?

A There has been a decrease in some practices that are considered undesirable or somewhat irregular, such as the use of polypharmacy, and there

has been an increase in the delivery of psychotherapies and adjunctive therapies.

Q What is polypharmacy, Doctor?

A The administration of two or more drugs of the same class at the same time.

Q You say there has been an increase in psychotherapies and adjunctive therapies?

A Yes.

Q What are adjunctive therapies?

A This is a residual category. In essense, it includes such things as educational therapies, vocational rehabilitation, occupational therapy, music therapy, art therapy, activities therapy, recreation.

Q Do you have an opinion as to whether schizophrenic patients have a high probability of developing chronicity?

A Yes, I do.

Q What is your opinion?

A The criteria in DSM-III almost makes chronicity a prerequisite for the diagnosis. So the probability then obviously becomes very high.

Q What are those criteria that almost make chronicity part of the diagnosis?

A They require either that there be more than

one attack in the course of the illness, in the history of the illness with never complete recovery between the attacks, or that the single attack lasts more than six months.

Q What is DSM-III?

A This is the manual published by the American Psychiatric Association which sets forth the standardized and agreed upon diagnoses used by the profession and the criteria for making those diagnoses. It is a largebook, something over an inch thick.

Q Have you had hearings involving schizophrenic patients who wanted to refusemedication?

A Yes.

Q How have you decided those cases?

A Some, I have affirmed; some, I have denied.

Q Do you have an opinion as to whether allowing patients to refuse medication increases the warehousing of such patients?

A Yes, I do.

Q What is your opinion?

A That it does not.

Q Why do you say that?

A Warehousing in fact is a term that is used to refer to the simple holding or housing of patients without the delivery of treatment.

If the use of informed consent for psychotropic medication has any influence on the matter at all, I would rather expect that it would decrease the warehousing inasmuch as one of the dangers of the effectiveness of medication is to tend towards the assumption that it is in and of itself sufficient for the treatment of the psychoses, a tendency which is undoubtedly augmented by the fact that it is also the cheapest of all treatments.

Q Do you have an opinion as to whether the policy as written as applied by you provides adequately that patients who in fact need the medication will get it?

A Yes, I do.

Q What is your opinion?

A That it does so provide.

Q What has been the experience on the cases that have been appealed to the independent psychiatrist? How many of those cases were appealed?

A I believe two.

Q What was the outcome of those appeals?

A The appeals both upheld my ruling.

MR. HOLME: No further questions.

MR. AUCOIN: May I ask a few questions?

MR. HOLME: Yes.

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DIRECT EXAMINATION

BY MR. AUCOIN:

Q You indicated that at the first of July, Dr. Lindner, the population at Lima State was 321 and that as of this week, approximately three months later, somewhere in the neighborhood of 240 patients.

Can you briefly state why the population has decreased approximately 80 patients during that three-month period?

A Yes, during or at the beginning of this period, a new maximum security hospital was opened on the grounds of the Central Ohio Psychiatric Hospital, and the Department of Mental Health during this period has been in the process of transferring the noncorrectional patients from Lima State Hospital to the two other available maximum security hospitals in the state.

Q So that the decrease in population had nothing to do with the implementation of the due process plan, did it?

A Not as far as I can see, no.

Q Earlier, you indicated that you felt that the nurses who observed patients essentially incompetent from a factual standpoint to consent to the administration of antipsychotic drugs determined

on their own initiative to refer those patients to you for hearing.

Do you know what the policy of Lima State Hospital with regard to the administration of psychotropic medication, how that addresses this type of problem?

MR. AUCOIN: Would you read the question back, please?

(Question read.)

THE WITNESS: I believe that the only reference to it is a section which, in essense, states a patient who is not competent to give consent in the opinion of the treating physician or the lay patient advocate, in that case, then the review process by the Clinical Director is to be initiated automatically.

BY MR. AUCOIN:

Q Do you know if patients have the availability of a lay advocate as a matter of course in all situations?

A Yes, I do.

Q What is the answer to that?

A They do.

Q Did the nurses and treatment staff of Lima State Hospital receive training with regard to the due process plan?

A Yes, they did.

Q Do you know approximately how many patients at Lima State Hospital are receiving antipsychotic drugs right now?

A I would estimate about 80 percent.

Q Do you know how many patients have been prescribed drugs by their treating psychiatrist, but have been allowed -- who have refused medication and their refusal has been upheld as of right now?

A Yes, I do.

Q How many is that?

A Approximately 16.

Q Do you know if all of the 16 people -- being more specific, do you know if the 10 people who refused medication and such refusal was upheld from July are still not taking medication?

A Yes, I do. There are some who are not and some who are.

Q Some may be taking medication at the present time?

A Yes.

Q So that the number is actually somewhat smaller than 16?

A Yes. The number -- just to be sure, could I have the second question back, please?

(Question read.)

MR. AUCOIN: Do you want to go off the Record a minute?

(Discussion off the Record.)

BY MR. AUCOIN:

Q Have any of the patients been represented by an attorney in these hearings?

A No.

Q Would that have changed the result of any of these hearings in your opinion?

A No.

Q Earlier, you indicated that some of the patients were confused as to their legal rights.

Could you be more specific?

Q A significant number of our patients are either too psychotic or too intellectually limited to understand a relatively complex legal document such as the hospital policy; furthermore, these limitations are sometimes so extensive that no amount of verbal interpretation or explanation by the staff can communicate to these successfully the principles and provisions involved; there are those patients who when told they have a limited right to refuse treatment, obtain the impression that they have an absolute right to refuse treatment and no amount of

explanation suffices to communicate to them, persuade them that there are limitations on that right.

MR. AUCOIN: I have no further questions.

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RECROSS EXAMINATION

BY MR. HOLME:

Q Was it your testimony, Doctor, that there were 10 cases in July where you upheld the patients' right to refuse?

A That is correct.

Q Of the patients who refused, I am curious as to why you say that some are now taking medication. First of all, let me just ask -- we are talking about a total of 16 cases approximately where you have upheld the patients' right to refuse. Is that so?

A Yes, sir.

Q Is it your testimony that of those 16 people, some are now taking medication?

A Yes.

Q If you know, why have some of those people begun taking medication again?

A In some cases, the patients themselves become persuaded that they should take the

medication voluntarily, or take a medication voluntarily.

In some cases, patients have had objections to specific brands of antipsychotic medication and have been willing to take other brands. Some patients have objected not to the principle of taking antipsychotic medication, but to the doses they were receiving.

Other patients who refused have had a return of symptoms that made them uncomfortable and have been willing to go back to their previous medication.

I am aware of at least one case in which there was a sufficient -- in which it appeared at the time of hearing that the patient might be able to get along without the medication, but, under trial, it turned out in fact that that was not the case and that the medication was refused.

Q Does the staff explain the policy on refusing medication to each patient?

A Yes.

MR. HOLME: That is all I have. Thank you.

(Deposition concluded at 10:25 a.m.)

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C E R T I F I C A T E

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The State of Ohio,
SS:
County of Franklin,

I, Judy E. Love, a Notary Public within and for the State of Ohio, do hereby certify that, before the giving of his said deposition, the said Lewis A. Lindner, M.D., was first duly sworn by me to tell the truth, the whole truth, and nothing but the truth;

That said deposition was taken in all respects pursuant to the stipulations of counsel heretofore set forth;

That the foregoing is the deposition given at the said time and place by the said Lewis A. Lindner, M.D.;

That I am not an attorney for or relative of either party and have no interest whatsoever in the event of this litigation.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 21st day of September, 1981.

Judy E. Love

Judy E. Love
Notary Public
State of Ohio

My Commission expires
March 31, 1983.